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Managed Risk Medical Insurance Board
HFP Advisory Panel Meeting Summary
May 10, 2011
Sacramento, California

Attendees: Jack Campana, Ellen Beck, Karen Lauterbach, Maria Tupas, Ronald Diluigi, Karen Lauterbach, Liliya Walsh.

MRMIB Staff: Ernesto Sanchez, Shelley Rouillard, Adriana Valdez, Liliana Diaz

1. Introductions

Mr. Jack Campana, Healthy Families Program (HFP) Advisory Panel Chairperson, opened the meeting by introducing himself and asking the Panel Members, the Managed Risk Medical Insurance Board (MRMIB) staff, and the audience to introduce themselves.

2. Review of the February 8, 2011 Advisory Panel Meeting Summary

The HFP Advisory Panel reviewed the November 9, 2010 meeting summary, and approved the summary as amended. (Revisions were made to page 5 and page 7.)

3. Advisory Panel Vacancy Update

Mr. Ernesto A. Sanchez, MRMIB's Deputy Director for the Eligibility, Enrollment, and Marketing Division, stated that MRMIB received five (5) letters from individuals who are interested in serving on the HFP Advisory Panel. He explained that the recommendations for the HFP Advisory Panel Member appointments will be presented to the Board at the May 12, 2011 meeting. There are two (2) vacancies in the areas of:

- Subscriber With Special Needs Child and;
- Disproportionate Share Hospital Provider.

Mr. Sanchez explained that MRMIB contacted the Disproportionate Share Hospital Organization and solicited their assistance to recruit candidates for the Disproportionate Share Hospital Provider vacancy. In the event Panel Members have any other suggestions on how to recruit interested individuals for these two (2) vacancies, he requested that Panel Members contact him. Dr. Beck also added that the Panel Member representing the subscriber with special needs child population must be a parent of a special needs child who is enrolled in Healthy Families.

4. State Budget Update

Mr. Sanchez explained that the Governor's proposed State Budget included premium increases to families in the HFP whose income levels are in Categories B and C. MRMIB would have to obtain federal approval from the Centers for Medicare & Medicaid Services (CMS) before program changes may be implemented. Dr. Beck inquired how much the proposed new monthly premiums would be. Mr. Sanchez explained that, in Category B, the new monthly premium would be $30 per child (with a maximum of $90 for 3 children or more). In Category C, the new monthly premium would be $42 per child (with a maximum of $126 for 3 children or more).

Mr. Sanchez also stated that the Governor's proposed State Budget also included an increase in co-pays for emergency visits to $50, as well as a $100 co-pay (per day) for in-patient hospital stays. Mr. Sanchez explained that the HFP co-pay changes are contingent upon receiving federal approval from CMS for the Department of Health Care Services' Medi-Cal Waiver.

Mr. Sanchez clarified that the Healthy Families out-of-pocket maximum will continue to be $250 per benefit year for the entire household (this program requirement will not change). Therefore, in the event federal approval is obtained to implement the co-pay changes, families may reach the $250 out-of-pocket maximum sooner. Once the out-of-pocket maximum is reached, families are no longer required to make payments for co-pays for the remaining part of the benefit year.

5. State Legislation

Mr. Sanchez stated that MRMIB will be closely monitoring the following bills: Assembly Bill (AB) 43, AB 62, AB 652, AB 1296, Senate Bill (SB) 36, and SB 703. AB 43 would change the Medi-Cal income eligibility levels for children ages 6-18 from 100% to 133% of the Federal Poverty Level (FPL). Currently, the Medi-Cal Percentage Programs provide coverage to children whose family's income is up to 100% of the FPL. This would also result in the Healthy Families Program implementing eligibility changes because the HFP currently covers children (from ages 6-18) up to 133% of the FPL.

Mr. Ron Diluigi explained that the county programs may also be impacted by the proposed eligibility changes identified in AB 43. He stated that it appears there may be overlapping eligibility requirements between the Healthy Families Program and the California Health Benefit Exchange. Mr. Sanchez explained that these types of policy discussions will be addressed by the Health Benefit Exchange during their monthly Board Meetings. Analysis, research, and studies are currently being conducted to determine where Healthy Families children will be best served – whether they should transition to Medi-Cal or to the Health Benefit Exchange or remain in Healthy Families. Mr. Diluigi agreed that research and analysis is critical to the policy making decision process. He further mentioned that the analysis should also consider the cost effectiveness of the transitioning the children to different programs or keeping them in Healthy Families.

6. HFP Update

Mr. Sanchez stated that the public use of the online Health-e-App (HeA) application was implemented on December 20, 2010. With this implementation, the general public now has access to apply for Healthy Families online, at any given moment. Previously, only Enrollment Entities (EEs) or Certified Application Assistants (CAAs) were able to apply online when assisting families. Since HeA public access was implemented, MRMIB has seen an increase of the number of applications submitted during the holidays, after hours, and on the weekends. MRMIB is very pleased with HeA being made available to the general public, because the online application makes it easier for families to apply for Healthy Families.

Mr. Sanchez explained that MRMIB continues to work on other types of HeA improvements. New forms will be added to enhance the HeA online functions. Families will be able to submit their Annual Enrollment Review (AER) information, Continued Enrollment (CE) forms, and Program Review (PR) forms online. Ms. Karen Lauterbach asked when these enhancements will be implemented. Mr. Sanchez stated that the changes will occur in the late-spring of 2011.

In addition, Mr. Sanchez reported that, sometime in 2011, HeA will also allow pregnant women to apply for the Access for Infants & Mothers (AIM) program. He indicated that Healthy Families has also implemented social media outreach efforts, through HFP Twitter and HFP Facebook.

6.b Open Enrollment

Mr. Sanchez stated that traditionally Open Enrollment (OE) occurred May 15th through July 31st each year. In 2010, MRMIB changed the OE period to begin July 15th through August 31st where plan transfer effective dates would occur on October 1st. This occurred because the OE process changed from the state fiscal year to the federal fiscal year.

Mr. Sanchez explained that families whose plans continued to be available in the new benefit year received postcards which informed them about the OE process. Families who were required to change their plans during the OE period received customized OE packets. He reported that roughly 427,000 OE postcards were sent to families and over 83,000 OE packets were mailed out. Of those 83,000 OE packets mailed to HFP families, roughly 3.5% of the families responded and requested for plan transfers. Mr. Sanchez reported that this has been the trend MRMIB has seen in the past.

Mr. Sanchez stated that, if families were required to change health plans and did not respond their children were automatically transferred to the Community Provider Health Plan. If the families were not satisfied with the new Community Provider Health Plan, they may request for a plan change within 30 days. He reported that less than 1% of these families requested to change to another health plan.

Mr. Sanchez reported that rating responses to the Health Plan Survey, for the most part, stayed consistent compared to previous years. Overall, the satisfaction rates were good. On the scale of 1 – 5, the health plan rating was a 4:1. The Dental Plan Survey rating was 2.8, which was consistent with previous years.

An audience member asked, if the HFP monthly premium increases due to the State Budget changes, how families will be notified of the program changes. Mr. Sanchez explained that adequate notice will be mailed out to families. He stated that families will have the opportunity to submit a Premium Re-Evaluated Form to see if they can lower their premiums should these program changes be implemented.

An audience member asked whether or not MRMIB will obtain federal approval first before notifying families about the HFP premium increases. Mr. Sanchez replied that the OE materials will continue to be mailed to families which identify the HFP monthly premium amounts that currently exist for the program. Mr. Sanchez explained that the proposed premium increases do not impact the OE process of OE program materials. He explained that if federal approval is obtained, families will then be notified of the increase in HFP premiums.

6.c. Summary of Model Contract Changes

Ms. Shelley Rouillard, Deputy Director of MRMIB's Benefits and Quality Monitoring Division (BQM), reviewed the final changes to the 2011-12 HFP health and dental plan model contracts. She began by addressing language that requires the plans to educate parents regarding how to obtain mental health and substance abuse treatment services. Ms. Rouillard indicated that the plans will report to MRMIB how they will educate parents and guardians about mental heath and substance abuse treatment services.

Ms. Rouillard noted that language to require the plans to track and report the length of time from the date a subscriber was referred for plan-provided mental health to the time they actually receive them was removed from the model contract. The plans said they do not have that data available because there are many reasons why subscribers do not keep appointments. Health plans can only report on the number of referrals made for mental health services.

Ms. Rouillard explained that staff recommended that plans report all copayments paid by subscriber households for covered services in the previous year not just those who reached the $250 maximum. Ms. Rouillard stated that the health plans said this was excessive and burdensome. Consequently, plans will continue to report only those families that reach the $250 copayment maximum.

Because MRMIB requires families to keep track of their copayments and notify the plan when they reach the $250 max ("shoe box method"), there is a new provision requiring the plans to provide subscribers two notices about the copay max and the process for notifying the plan when the family reaches the max. The contract requires plans to send the 2nd reminder notification in the 3rd quarter of the benefit year. In addition, plans could increase awareness in the HFP handbook and other member material.

Ms. Rouillard stated that a new provision requires plans to designate at least one of the plans' employees as a Dental Plan Liaison to coordinate benefits and services and resolve issues with a subscriber's dental plan.

There is new language requiring the plans to increase awareness about the importance of routine pediatric dental care and encourage pediatricians to educate parents about oral health and the need to visit the dentist for check-ups during well-baby visits.

Ms. Rouillard noted a new provision that allows MRMIB to receive encounter data back to January 2008. Plans must provide encounter and claims data no later than 60 days after requested by the state, and submit encounter and claims data no later than 180 days after the end of the month in which a service is rendered.

Audience member, Elizabeth Abbott from Health Access had a follow up concern regarding the deletion of the requirement to track mental health appointments. Ms. Abbott stated there is a law known as "Timely Access" in California which requires appointments be scheduled within a certain time frame. Ms. Abbott was unhappy with the HFP contract language because the plans are not being held accountable. She said the Department of Managed Health Care (DMHC) had been in discussions with stakeholders recently regarding this. Ms. Abbott said this may have a huge impact on HFP subscribers she feels it is very important to have a liaison to follow up with. Ms. Abbott asked why where there not stricter requirements on the plans. Ms. Rouillard replied that all plans regulated by the DMHC would have to adhere to the requirements of state law. Ms. Rouillard said the plans were not off the hook and they still needed to follow requirements. Mr. Diluigi stated he wanted clarification on the question. Ms. Rouillard clarified that the language for tracking the time from mental health referral to mental health appointment had been taken out of the 2011-12 contract at the last Board meeting.

Dr. Beck stated she understands this is a difficult issue. She was glad Ms. Abbott was bringing it to the panel's attention. Dr. Beck asked if the language could be reconsidered by the Board.

Mr. Campana stated that maybe a phrase could be added to the contract to say: "As required under State statute, Contractors must track and report."

Ms. Rouillard was asked why this language was taken out? She responded that the plans could not track this information.

Mr. Diluigi asked if the board was fine with removing this provision. Ms. Rouillard said that the plans wanted money in order to do this but there is no money so the board agreed to drop this requirement. Mr. Campana asked if MRMIB could require language stating "in compliance with state statute." Ms. Rouillard responded that MRMIB does have language in the contract that plans must comply with all Knox-Keene Act requirements.

Mr. Diluigi stated that if the plans were going to have to track and report the information as required by state law, it didn't have anything to do with MRMIB giving them money. This is a requirement anyway.

Mr. Sanchez added that the Board had to make tough choices on how firm they wanted to be in contract language when state law already required certain things.

Dr. Tupas added the health plans have utilization management committees that track referrals but they don't track the period between referral and appointment. They also track denials as well.

Ms. Rouillard noted that plans have a way of tracking referrals but what they cannot track is when the child makes an appointment and actually goes to the appointment. She also noted this provision was a recommendation from the Mental Health Evaluation; that is why MRMIB proposed it.

Dr. Beck added that it is the Advisory Panel's responsibility to advocate for the families. Dr. Beck added that since DMHC was required to get these reports, MRMIB should ask for a copy.

Ms. Abbott said that implementation of timely access regs was delayed one year and went into effect January 11, 2011. She said the plans need to figure out how to do this; this is the cost to do business in California. Ms. Abbott thought even though DMHC was the enforcing department behind this issue, she asked MRMIB to support its sister agency and ask for the performance reports. Ms. Rouillard added that MRMIB can get this information from DMHC.

Mr. Diluigi stated that this is part of law and should be enforced, and that MRMIB should request information from DMHC in regards to this issue. Ms. Rouillard responded that MRMIB gets plan monitoring reports from DMHC.

Ms. Beck would like to ask to reconsider including language on this issue.

Liliya Walsh suggested having the plans track the availability of specialists, not only when the family made their appointment but also when they were seen.

Dr. Tupas added, in primary care, they measure timely access performance based on the third "next available" appointment because it is the most accurate measure. Ms. Tupas said the first and second appointment times are not measured because the family may not be able to make those appointments for a variety of reasons. She has seen how the most accurate measure is the third offered appointment because that is usually when the family keeps the appointment.

Mr. Campana recommended that plans provide documentation to MRMIB of their compliance with state statute.

The Panel made the following Motion:

> The Healthy Families Advisory Board recommends to the Board to include the following language in the 2011/2012 contract with health plans: ***"Plans shall demonstrate how they will comply with timely access regulations promulgated by the DMHC and shall report to the Board on their performance."*** The motion passed.

This will be presented to the Board at the May 26, 2011 meeting.

Dr. Beck would like to know if there any other way to track receipts besides the shoe box method. Ms. Walsh suggests including something on the HFP web page that would offer sample forms and make a statement about the importance of families keeping receipts from doctor visits. Ms. Walsh said that the families can request a summary of visits from their doctor; they can see if they have exceeded $250. Ms. Walsh understood that it was still the family's responsibility to keep track, but wanted to give families a way to track their copayments and seek reimbursement.

Ms. Walsh asked if a child was referred to a specialist that was more than 60 miles away, is there a provision that allows the child to see a specialist outside of the network and if so, what would the process be? Ms. Rouillard responded that, in general, plans would not allow it, unless they give permission. She said the family would have to go through an authorization process. Ms. Rouillard explained that the health plan member could dispute a denial of specialist care through the DMHC which has a process called "Independent Medical Review," or IMR. IMR looks at the medical necessity of the service. Ms. Walsh concluded that this sounded too complicated.

Ms. Rouillard moved on to the Dental Model contract amendment language. There is a new provision that clarifies the plan's responsibility to provide covered services to treat a California Children Services (CCS) condition in the event the CCS Program does not provide the services needed to treat CCS-eligible condition. If a child is referred to CCS for dental services, and the CCS program cannot or will not provide the services then the plan must provide the covered service. If the dentist recommends a service and the plan doesn't cover it then the plan is not responsible for providing it.

Ms. Rouillard noted that the model dental contract includes a requirement to establish a Health Plan Liaison. Another provision requires the plans to notify subscribers twice a year of the benefits of periodic oral health exams. Dental plans must provide encounter and claims data retroactively to January 1, 2008, and collaborate with the State and its contacted consultants to develop and implement quality improvement projects.

Ms. Rouillard clarified that plans would report performance measures based on calendar year 2011 data. MRMIB will monitor these standards and take action if the standards are not met. The Board wants to focus on overall utilization of dental services. The Board wanted 100% of children to be seen each year but due to financial circumstances and since the dental HMOs were nowhere near 50%, MRMIB set the minimum performance level at 50% for HMOs and, 67% for Exclusive Provider Organizations (EPO).

Attachment XX establishes the Minimum Performance Levels (MPL) for each of the dental measures. MRMIB set the MPL at 80% of the 2009 HFP weighted average, giving all plans an incentive to improve.

Dr. Beck asked to clarify the process for plan input into the model contracts. Ms. Rouillard stated that MRMIB presents the draft contracts to the Board at two meetings. At the first meeting, MRMIB presented the Health and the Dental model contracts for 2011-2012. Plans had a couple of weeks to review it and give MRMIB their recommendations. At the second meeting, MRMIB presented the Board a document with the proposed changes, the plans' comments, and MRMIB staff recommendations. The Board reviewed all the comments and decided which provisions to keep, change, or delete.

An audience member asked, under the Budget Detail and Payment Provisions in Exhibit B of the model contract, why is the Minimum Loss Ratio (MLR) percentage left blank? Ms. Rouillard responded that the MLR is specific to each plan.

Dr. Beck wondered if MRMIB thought about having the HFP children seen by a dentist by the end of two or three years of age. Ms. Rouillard replied by saying that this was one of the elements of the oral health quality improvement project that MRMIB is conducting.

6.d. Quality Assessment and Improvement Strategy and External Quality Review Organization (EQRO) Solicitation

Ms. Rouillard reported a solicitation going out on Monday, May 16, 2011 to contract with an External Quality Review Organization (EQRO). This is a requirement under CHIPRA. The EQRO will validate performance measures allowing MRMIB to understand the plans' capacity to gather and report data accurately and how MRMIB can use this data to conduct Quality Improvement Projects (QIPs). There will be two quality improvement projects. One will be a statewide project all plans will participate in. The other QIP will be plan specific. Each plan will choose one area it wants to improve based on its own data and the needs of its population. The EQRO will do compliance reviews regarding how well the plans comply with federal and state standards including regulations, statutes, and contracts. The EQRO will also validate Maximus' process for validating encounter data as well as plan encounter data submissions. The EQRO will conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient satisfaction survey. The EQRO will provide technical assistance to the plans. Potential EQRO contractors will submit their proposals to MRMIB by mid-June with a contract effective date of October 1, 2011.

6e. Oral Health Quality Improvement Project Update.

Ms. Rouillard told the panel MRMIB has contracted with the Center for Health Care Strategies, through a grant from the California HealthCare Foundation to conduct an oral health quality improvement project. MRMIB wants to improve access to diagnostic and preventive treatment for HFP children ages 0-7. In addition, MRMIB hopes to increase the number of children who have a regular and continuous source of dental care, and increase the number of children 24 months old who have been seen by a dentist. MRMIB will aim to drive integration of medical and dental services, identify high-risk or at-risk children, and increase the number of young children who receive fluoride varnish.

MRMIB and the plans are conducting a pilot project in four Southern California counties: San Diego, Los Angeles, Santa Barbara and Ventura. MRMIB picked these four counties because all six HFP dental plans are in these counties. MRMIB hopes that plans take what they learn and apply it in other service areas. This program focuses in Southern California because that is where the concentration of dental HMOs are. MRMIB is working with CHCS and the plans to develop strategies and engage plans to improve their performance. Ms. Rouillard added that the plans are very enthusiastic about this project.

One aspect of the project is to identify dentists interested and willing to treat young children 0-7. This project will produce a "preferred provider directory" of dentists across all the plans that are willing to see these young children. Plans will be developing outreach strategies to target at-risk children and developing culturally appropriate oral health materials. In addition, plans will be working with community organizations that are already involved in oral health such as school-

based programs, First 5 and so on. Instead of having all the children going to the dentist's office there would be places for dental professionals to go in order to provide these services. The plans are considering offering incentives to get more general dentists to treat young children, and offering training developed by the California Dental Foundation.

MRMIB will collect data quarterly from the plans on 5 measures:

- Rate of year one dental visits;
- The number of children under two who see a dentist;
- Preventive dental services and number of children who received preventive services,
- Number of children who got exams and oral health evaluations; and
- The number of children who received treatment and prevention of caries.

MRMIB will begin receiving the plan data in July.

Dr. Tupas asked if MRMIB would be tracking access for kids with special needs that general dentists are not comfortable serving? Ms. Rouillard responded that MRMIB doesn't have a specific strategy for children with special needs as part of this project.

Ms. Rouillard said there are several health plans interested in partnering with dental plans for better medical-dental integration. Health Net has both a health and dental plan in at least one of the counties. Health Net wants to evaluate its data to see what impact oral health has on medical costs. A health plan in San Diego advised MRMIB that it is willing to partner with one of the dental plans for a similar analysis.

Dr. Forester from the audience stated that it would be great to reach out to the young population. Dr. Forester recommends incentives for specialists as well as general dentists, because specialists see these children down the road. Dr. Forester thanked MRMIB for doing this project adding dentists have been talking about this for a long time.

Ms. Abbott asked, what are MRMIB's plans to share these studies with the public? Ms. Rouillard replied that staff will share the results with the Board and the public at Board meetings. Ms. Rouillard added that all MRMIB reports are posted on the MRMIB website.

Dr. Beck inquired about how could she share or encourage families to participate in this project. Ms. Rouillard responded that the plans would be contacting families in the four counties and families should work with their plans.

6.f. Update on Encounter Data Project

Ms. Rouillard said that 18 out of 25 Health Plans have submitted encounter data. MRMIB is optimistic that by the end of this year all health and dental plans will be submitting monthly encounter data.

6g. Update on the Advisory Committee on Quality

Ms. Rouillard said the Advisory Committee on Quality (ACQ) meeting on April 28 focused on the HFP quality strategy. It was strongly recommended that MRMIB talk to the health plans about what the statewide QIP should be. The committee discussed how to use race, ethnicity, and language data in quality improvement.

Dr. Beck asked about the process to identify the quality activities. Ms Rouillard explained that one tool for the plans are the 2009 Plan Performance Profile Report that is going to the Board May 12th. The report shows the plans' performance on HEDIS over 3 years. This report could help the plans identify areas where they need to improve individually and as a group.

Dr. Beck wondered if the Advisory Panel would receive a summary and report at the next meeting. Ms. Rouillard responded that MRMIB would present this information to the Board and at the next Advisory meeting and that all the information could be found on the MRMIB website after it was presented to the Board.

7. Informational HFP Reports

Mr. Sanchez highlighted important informational reports that the Advisory Panel should be aware of. He mentioned that a Resolution was made by the Board to amend the Administrative Vendor Contract with MAXIMUS. The purpose of the amendment was to include funding to conduct outreach for Health-e-App public access.

Mr. Sanchez also reported that the Centers for Medicare & Medicaid Services (CMS) is offering $40 million in grant funds to be made available for a two-year cycle. The proposals must focus on one of the five areas: 1) using technology to facilitate enrollment and renewal; 2) focusing on retention; 3) engaging schools in outreach; 4) reaching out to groups of children who are likely to experience gaps in coverage; or 5) insuring eligible teens. The grants will range in size from $200,000 up to $1 million for all but the first category, which has a grant range of $200,000 to $2.5 million. MRMIB applied for the federal grant, specifically focusing on the use of technology to facilitate enrollment and renewal.

Mr. Sanchez explained that in MRMIB's grant application, they are focusing on adding functionality and an income calculation to the existing Health-e-App public access project. This would create an interface with the Internal Revenue Service and allow MRMIB to ascertain the family's income immediately, rather than having the family submit income documentation to verify their income. If adequate funding is awarded to MRMIB, staff proposes additional Health-e-App functionality for the mid-year Premium Re-Evaluation Form. This process allows families at any time during the 12-month eligibility period, to submit changes in their income in order for the HFP to determine whether the premiums will be adjusted or whether the child now qualifies for Medi-Cal. Mr. Sanchez reported that the grant proposal is consistent with the principles outlined in the Affordable Care Act, which includes the proposed use of data matching using tax records as evidence of eligibility instead of paper documentation. Another ACA principle is that families should be able to apply, renew, and edit their eligibility information on-line.

CMS will award grants in late-July 2011. Awarded grants will cover the period of July 30, 2011 through July 29, 2013.

To access these reports, please click on the links below the agenda item.

Mr. Campana announced the meeting was adjourned. The next meeting will be August 9, 2011. The fall meeting will be November 8, 2011.